Center for Operations and Pharmacy Management
Drug Utilization Review (DUR) Board Meeting Minutes
Wednesday September 16, 2009
Electronic Data Systems Conference Room
171 Service Avenue
Warwick, Rhode Island

DUR Board Members Present:	Michelle Booth RPh Tara Higgins, RPh, CGP, CDOE Stephen Kogut, PhD, RPh, MBA Ray Maxim, MD Ellen Mauro, RN, MPH Richard Wagner, MD
Others Present:	Paula Avarista, RPh, MBA (RI Medical Assistance Program) Ann Bennett (Electronic Data Systems) Karen Mariano (Electronic Data Systems) Joe Paradis, PharmD (Health Information Designs)

There were no changes made to the minutes from the June 3, 2009 meeting.

Paula Avarista addresses some issues that were discussed at the Pharmacy and Therapeutics (P&T) Committee meeting held yesterday on September 15, 2009. It was noted that there are very few claims for peginterferon alfa-2A (Pegasys®) and peginterferon alfa-2B (Pegintron®). Based on the size of the Medicaid population it would be expected that the occurrence of hepatitis C would be higher than the use of peginterferon suggests. The concern was that there may be patients with a diagnosis of hepatitis C who are not being aggressively treated. There was also discussion regarding difficulties in getting patients referred to specialist for hepatitis treatment. HID will query the data and provide the State with a list of patients who have a diagnosis of hepatitis C and are not receiving treatment with peginterferon.

The size of the remaining fee-for-service population was discussed. It is anticipated that by the end of the year the population may be approximately 3,500 patients.

There was discussion regarding differences among all the various drug formularies maintained by the health plans in Rhode Island. The Board recommended that a list of highly prescribed drugs (top 100 drugs) be prepared to indicate formulary coverage across all the various plans including Blue Cross, Neighborhood, UnitedHealthcare, Medicaid fee-for-service and RIPAE. If such a list were to be prepared, it could be posted on the State's website. It was also recommended that for those drugs with exceptions to coverage that would not normally be expected, such as brands that are preferred over generics, that an explanation be added.

HID reported on efforts to addresses non-adherence with a number of therapeutic agents, such as antihypertensives, lipid lowering drugs, antidepressants and antipsychotic agents. A summary of DUR letters mailed and response rates was reviewed. There are now nurse case managers available to follow up with patients to help improve adherence. It was suggested that if there is no response from the prescriber to the DUR letter, that a copy of the letter should be provided to the nurse case manager for follow up. Paula

Avarista suggested that it may be beneficial to copy all DUR letters addressing non-adherence to the nurse case manager or to provide them with a list of patients who were selected for intervention. Ellen Mauro suggested that it may also be possible to identify patients based on specific indicators, such as patients with diabetes who have HbA1C values of greater than 7%. Another indicator that could be evaluated would patients with diabetes who are not being treated with lipid lowering therapy.

Board members suggested evaluating patient who are non-adherent to mental health drugs and determine if they have higher rates of hospitalizations than would be expected in the average population of patients with a mental health diagnosis. Dr. Kogut recommended that hospitalization rates in these patients be compared to a control group of patients. Dr. Wagner suggested that patients with continuous eligibility and considerable historical data could be used as their own control. Hospitalization rates before and after it was found that patients became non-adherent could be compared. Paula Avarista asked if HID could send her a list of recipients who were found to be non-adherent to antidepressants or antipsychotics for further evaluation.

The use of duplicate antipsychotic agents was discussed. HID repeated its analysis of claims data over a four month time period to evaluate the use of two or more antipsychotic agents for 90 days. Previously HID evaluated only the use of duplicate atypical antipsychotic agents. However, for this evaluation all antipsychotic agents were included. The rate of duplicate use of antipsychotic agents was found to be 7.5% of the total population with at least one claim for any antipsychotic agent. This rate was higher than other comparable states. Paula Avarista asked HID to send her the list of patients taking duplicate agent.

Dr. Wagner discussed the use of duplicate antipsychotic agents that may be clinically justified such as the use of clozapine and another agent and the use of a rescue oral medications in those patients on long acting injectable agents. It was noted that the use of low dose quetiapine for its sedative properties and another agent continues to be an ongoing issue. Dr. Kogut also noted that the use of quetiapine three times daily is likely an indication that the drug is being used off label for the treatment of anxiety.

Dr. Wagner noted that from his past experience with the Community Medication Assistance Program (CMAP) program, all claims for quetiapine less than 200mg daily required the prescriber to request an authorization and provide an indication for its use. The Board discussed if it would be prudent to continue sending DUR letters addressing the issue of duplicate antipsychotic therapy being that efforts to reduce the rate of duplicate therapy have not proven to be very effective. It was decided to focus on the use of duplicate therapy for those patients utilizing a long acting injectable agent. The Board asked that HID monitor the number of patients using both a long acting injectable and an oral agent as a percentage of all agents on long acting injectable agents. The Board also advised to continue sending DUR letters to prescribers for those patients receiving a long acting injectable agent along with an oral agent.

The utilization of buprenorphine/naloxone (Suboxone®) was discussed. There continues to be only a few patients found each month with claims for buprenorphine/naloxone (Suboxone®) along with concurrent claims for other opioids. The Board asked that HID continue to monitor the number of patients taking both agents and to report the data as a percentage of all patients taking buprenorphine/naloxone (Suboxone®). Tara Higgins indicated that Blue Cross is evaluating the use of buprenorphine/naloxone (Suboxone®) and has noted some claims for higher doses of the drug. Blue Cross is finding that some prescribers follow more than 100 buprenorphine/naloxone (Suboxone®) patients in their practice. Current buprenorphine/naloxone (Suboxone®) certification guidelines recommend that individual prescribers limit their practice to 100 patients.

At the previous DUR Board meeting, HID was asked to monitor the use of insulin vials and pens. The P&T Committee had previously recommended that rapid acting insulin pens be made preferred. There was concern that this may increase the use of the more costly pens in patients who would normally use vials. At this time there is not enough data to show any trend in the increased use of rapid acting pens as compared the vials.

There was discussion of developing a means of monitoring adherence with insulin therapy. Suggestions included monitoring the use of syringes, test strips or selecting patients for intervention who do not have claims for insulin filled at least every 60 days.

The use of muscle relaxants and opioids was discussed. The Board suggested that DUR efforts be focused on those patients with different prescribers for opioids and muscle relaxants. Paula Avarista also asked for HID to send her a list of recipients concurrently taking opioids and muscle relaxants.

The next meeting is scheduled for Wednesday December 2, 2009 at 8:00am.